RYAN WHITE TITLE I PROGRAM
Prior Authorization Form for Procrit® (Epoetin)

Recipient's Full Name:_____ Date of Birth: _____ /_____ /_____
Prescriber Full Name:_____ Prescriber License #: (ME,OS,RN)_____
Prescriber Telephone #:_____ Prescriber Fax #:_____
Drug Strength: _____

Please check below the diagnosis or indication for this product:

- □ Anemia associated with HIV
- □ Anemia associated with renal failure if patient is not on dialysis
- □ Anemia associated with chemotherapy
- □ Other _____

Select one of the following:

New Therapy □ **OR** Continuation of Therapy □

Does the patient have active gastrointestinal bleeding? □ YES **OR** □ NO

Lab Test Date:_____ Hematocrit:_____% Hemoglobin:_____g/dl

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Mail or Fax information to: Mercy Professional Pharmacy
3661 South Miami Avenue, Suite 110
Miami, FL 33133
Telephone #: (305) 285-2762 (for information only)
Fax #: (305) 285-5019 **OR** (305) 285-2606

FOR RYAN WHITE TITLE I USE ONLY

Date: _____ **Notified:** _____

Approved: _____ **Start Date:** _____ **Expiration Date:** _____

Denied: _____ **Reason:** _____

Please note: All questions should be addressed to Mr. Daniel T. Wall, Assistant Director, Office of Strategic Business Management, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I Professional Service Agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Rev. 3/23/05